CHAPTER II

PROVIDER PARTICIPATION REQUIREMENTS

CHAPTER II
TABLE OF CONTENTS

CHAPTER II
TABLE OF CONTENTS (continued)

CHAPTER II
PROVIDER PARTICIPATION REQUIREMENTS

PARTICIPATING PROVIDER

The Virginia Medical Assistance Program covers two types of health care services for Medicaid-eligible children in Virginia schools. General school services are for special education students and clinic services are for all students.

General school services include rehabilitation therapy (physical therapy, occupational therapy, and speech-language pathology services), psychiatric/psychological services, and hearing screenings. To provide these services, a participating provider must be an institution, facility, agency, person, partnership, corporation, or association certified by the State Department of Health and holding a current, signed participation agreement with the Department of Medical Assistance Services (DMAS).

A school division may bill for Medicaid-covered clinic services if it has a current participation agreement with DMAS for clinic services. This agreement is required for a school division to bill for medical services such as screenings. If a school division wants only to bill for outreach services, it must have the outreach services agreement described later in this chapter.

PROVIDER ENROLLMENT

Any provider of services must be enrolled in the Virginia Medical Assistance Program (Medicaid) prior to billing for any services provided to Medicaid recipients. Copies of provider agreements are found within this chapter. All providers must sign the appropriate Participation Agreement and return it to the Provider Enrollment and Certification Unit; an original signature of the individual provider is required. The authorized agent of the provider must sign an agreement for a group practice, hospital, or other agency or institution. The Virginia Medical Assistance Program must receive prior written ratification of the identity of any designated authorized representative and the fact that a principal-agent relationship exists.

Upon receipt of the above information, a provider number is assigned to the school division. This number must be used on all claims and correspondence submitted to DMAS.

For the provision of general school services, the school division must be enrolled in the Medicaid Program prior to a school division's billing for any services provided to Medicaid recipients. The Participation Agreement must have the appropriate signature(s) and must be returned to the Provider Enrollment and Certification Unit at DMAS. (Exhibit II.1 contains a copy of the Participation Agreement.)

For the provision of school clinic services, the school division must be enrolled in the Medicaid Program prior to billing for school-based services provided to Medicaid recipients. The Participation Agreement must have the appropriate signature(s) and must be returned to the Provider Enrollment and Certification Unit at DMAS. (Exhibit II.2 contains a copy of the Participation Agreement.) Upon receipt of the above information, a provider number is assigned to the school division for billing. This number must be used on all school-based health clinic claims and correspondence submitted to DMAS.

School divisions enrolled with DMAS for both general and clinic services will receive only one provider number for billing for both types of services.

This manual contains instructions for billing and specific details concerning the Medicaid Program. Providers must comply with all sections of this manual to maintain continuous participation in the Medicaid Program.

REQUESTS FOR PARTICIPATION

To become a Medicaid provider of services, the provider must request a participation agreement by writing to:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-5105 or 1-888-829-5373 (in state toll-free), fax – 804-270-7027

Note: Certification by the Virginia Department of Education does not constitute automatic enrollment as a Medicaid provider.

PARTICIPATION REQUIREMENTS

Providers approved for participation in the Medical Assistance Program must perform the following activities as well as any other specified by DMAS:

- Immediately notify the Department of Medical Assistance Services, in writing, of any change in the information previously submitted to DMAS by the provider.
- Assure freedom of choice to recipients in seeking medical care from any institution, pharmacy, or practitioner qualified to perform the service(s) required and who participates in the Medicaid Program at the time the service was performed.
- Assure the recipient's freedom to reject medical care and treatment.
- Provide services and supplies to recipients in full compliance with Title VI of the Civil Rights Act of 1964 which prohibits discrimination on the grounds of race, color, or national origin.

- Provide services and supplies to recipients in full compliance with the requirements of the Rehabilitation Act of 1973 requiring that all necessary accommodations are made to meet the needs of persons with semi-ambulatory disabilities, sight and hearing disabilities, and disabilities of coordination (refer to the section regarding the Rehabilitation Act).

- Provide services and supplies to recipients in the same quality and mode of delivery as provided to the general public.

- Charge the Department for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges to the general public.

- Not require, as a precondition for admission or continued stay, any period of private pay or a deposit from the patient or any other party.

- Accept Medicaid payment from the first day of eligibility if the provider was aware that an application for Medicaid eligibility was pending at the time of admission.

- Accept as payment in full the amount established by the Department to be the reasonable cost or the maximum allowable charge. 42 CFR, Section 447.15 provides that a State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency. The provider must not attempt to collect from the recipient or the recipient's responsible relative(s) any amount that exceeds the usual Medicaid allowance for the service rendered. For example: If a third party payer reimburses $5.00 out of an $8.00 charge, and Medicaid's allowance is $5.00, then payment in full of the Medicaid allowance has been made. The provider may not attempt to collect the $3.00 difference from Medicaid, the recipient, a spouse, or a responsible relative.

- Accept assignment of Medicare benefits for eligible Medicaid recipients.

- Use Program-designated billing forms for the submission of charges.

- Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the health care provided.

  Such records must be retained for a period of not less than five years from the date of service or as provided by applicable state laws, whichever period is longer. If an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved. (Refer to the section regarding the documentation for medical records.)

- Furnish to authorized State and federal personnel, in the form and manner requested, access to records and facilities.

- Disclose, as requested by the Program, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to recipients of medical assistance.

- Hold confidential and use for authorized Department purposes only all medical assistance information regarding recipients. A provider shall disclose information in his or her possession only when the information is used in conjunction with a claim for health benefits or the data is necessary for the functioning of the State Agency. The State Agency shall not disclose medical information to the public.

PARTICIPATION CONDITIONS: SPECIAL EDUCATION SERVICES

All providers enrolled in the Virginia Medical Assistance Program must adhere to the conditions of participation outlined in their individual provider agreements. The following paragraphs outline the special participation conditions for providers serving students in special education. DMAS covers physical therapy, occupational therapy, and speech-language pathology services in school divisions under the conditions listed below. To become a provider in this category, the provider must:

- Employ qualified physical or occupational therapists or speech-language pathologists whose qualifications are certified by the Virginia Department of Education;

- Only bill Medicaid for psychiatric or psychological services provided by qualified clinicians who are employed by the schools; and

- Enter into and have in effect an agreement as a Medicaid provider of services to special education students.

SCHOOL-BASED OUTREACH SERVICES AGREEMENT

To receive payment for outreach services, a school division must have a written agreement to perform outreach services to Medicaid-covered children with the Virginia Department of Education (DOE). DMAS has an interagency agreement with DOE for coverage of outreach services to Medicaid recipients. Requirements are stated for the coverage of outreach services, such as provider qualifications, whereby the outreach coordinator must be at a minimum a registered nurse. DOE contracts with school divisions for the outreach services. Further information may be obtained from:

School Health Services Coordinator
Division of Regional Services - 20th floor
Department of Education
P.O. Box 2120
Richmond, Virginia 23216-2120

PARTICIPATION CONDITIONS: OUTREACH COORDINATOR

The outreach coordinator is a registered nurse (R.N.) employed by the school division. The R.N. must be licensed in Virginia and should have a minimum of one year of experience in community nursing and experience in working with children. The responsibilities for this position are described in Chapter IV.

PAYMENT FOR COVERED SERVICES

Payment for covered services by DMAS will reflect the federal matching share of the payment only. Three forms have been developed to be completed by the school division to document State and local funds for matching with the federal funds. The type of service rendered will determine which form to use. Copies of the quarterly financial certification forms are included in Exhibits II.3-5. For more information on the forms, see Chapter V.

REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT

Section 504 of the Rehabilitation Act of 1973 provides that no handicapped individual shall, solely by reason of the handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. As a condition of participation, each Medicaid provider has the responsibility for making provision for handicapped individuals in his or her program activities.

As an agent of the federal government in the distribution of funds, DMAS is responsible for monitoring the compliance of individual providers. By signing the check, the provider indicates compliance with Section 504 of the Rehabilitation Act.

In the event a discrimination complaint is lodged, DMAS is required to provide the Office of Civil Rights (OCR) with any evidence regarding compliance with these requirements.

REQUIREMENTS OF THE CIVIL RIGHTS ACT OF 1964

All providers of care and suppliers of services under contract with DMAS must comply with the requirements of Title VI of the Civil Rights Act of 1964 which requires that services be provided to Medicaid recipients without regard to race, color, or national origin.

CERTIFICATION AND RECERTIFICATION

The Virginia Medical Assistance Program depends upon the participation and cooperation of physicians who provide or order many health care services. For general school services such as physical therapy, occupational therapy, speech-language pathology services, and psychiatric or psychological services, the physician must certify that the service is medically necessary and that the treatment prescribed is in accordance with excellence in medical practice.

The certification and recertification statement for physical therapy, occupational therapy, and speech-language pathology services must contain the following information:

- An adequate written record of the reasons for the admission and continued treatment of the patient for rehabilitative services;
- The estimated period of time the patient will continue to require the services; and
- Any plans, where appropriate, for post-hospital care.

Certifications and recertifications must be signed by the physician responsible for the case or by another physician having knowledge of the recipient's care and who is authorized to sign by the responsible physician.

DOCUMENTATION OF RECORDS: GENERAL SCHOOL SERVICES

The provider agreement requires that the medical records fully disclose the extent of services provided to Medicaid recipients. The following elements are required documentation for medical records:

- The record must identify the patient on each page;
- Entries must be signed and dated by the responsible licensed participating provider. Care rendered by personnel under the supervision of the provider, in accordance with Medicaid policy, must be countersigned by the responsible licensed participating provider;
- The record must contain a preliminary working diagnosis and the elements of the history and physical examination upon which the diagnosis is based;
- All services, as well as the treatment plan, must be entered in the record. Any drugs prescribed as part of a treatment, including the quantities and the dosage, must be entered in the record; and
- The record must indicate the progress being made, any change in the diagnosis or treatment, and the response to treatment. Progress notes must be written as required for the provider type.

For other record documentation requirements, see Chapter IV.

DOCUMENTATION OF RECORDS: CLINIC SERVICES

The provider agreement requires the medical records to fully disclose the extent of services provided to Medicaid recipients. The following elements are required documentation for medical records:

- The record must identify the child on each page;
- Entries must be signed and dated by the responsible licensed participating provider; and
- The record must show positive and negative examination findings, any diagnostic tests ordered and the results of the tests, any diagnoses, an indication of whether further treatment is needed, any referrals including the name of the referring physician, and documentation of care rendered by personnel under the direct personal supervision of the licensed participating provider.

LIABILITY INSURANCE FOR ACCIDENTAL INJURIES

The Virginia Medical Assistance Program will seek repayment from any settlements or judgments in favor of Medicaid recipients who receive medical care as the result of the negligence of another. If a recipient is treated as the result of an accident and the Virginia Medical Assistance Program is billed for this treatment, Medicaid must be notified promptly so action can be initiated by Medicaid to establish a lien as set forth in the Virginia Code Section 8.01-66.9. In liability cases, providers may choose to bill the third-party carrier or file a lien in lieu of billing Medicaid.

In the case of an accident in which there is a possibility of third-party liability or if the recipient reports a third-party responsibility (other than those cited on his or her Medical Assistance Identification Card), and regardless of whether Medicaid is billed by the provider for rendered services related to the accident, the school division must forward the DMAS-1000 (Exhibit II.6 contains a sample of this form) to the attention of:

Third-Party Liability Casualty Unit
Virginia Medical Assistance Program
600 East Broad Street
Richmond, Virginia 23219

HEALTH INSURANCE COVERAGE

The U.S. Department of Education, Office of Special Education Programs (OSEP), policy papers make it clear that parents must not incur any financial loss or cost. The Medicaid program is by law, the payer of last resort. Therefore, the Department of Medical

Assistance Services will reject any claim for Medicaid reimbursement for services if it is determined that other third party insurance is available and has not been accessed by the local school division. If a third party resource is identified by DMAS after a claim is paid, the DMAS Third-Party Liability Unit must void the claim to recoup the funds.

TERMINATION OF PROVIDER PARTICIPATION

The participation agreement will be time-limited with periodic renewals required. DMAS will request a renewal of the Participation Agreement prior to its expiration.

A participating provider may terminate his or her participation in Medicaid at any time. However, written notification of voluntary termination must be made to the Director, Department of Medical Assistance Services thirty (30) days' prior to the effective date.

DMAS may terminate a provider from participation upon thirty (30) days' written notification prior to the effective date. Such action precludes further payment by DMAS for services provided recipients subsequent to the date specified in the termination notice. Termination by DMAS shall be treated as an adverse action, and the provider shall be entitled to a reconsideration and/or hearing as identified in the following section.

The Code of Virginia, Section 32.1-325.C, mandates that "Any such (Medicaid) agreement or contract shall terminate upon conviction of the provider of a felony." A provider convicted of a felony in Virginia or in any other of the 50 states must, within 30 days, notify the Department of this conviction and relinquish the agreement. Reinstatement will be contingent upon the provisions of State law.

RECONSIDERATION OF ADVERSE ACTIONS

A provider cannot bill a recipient for services if the services are not covered by Medicaid due to the provider's failure to obtain preauthorization or to perform other required administrative functions.

Any decision concerning the continued placement made by the attending physician is not appealable to DMAS.

Non-State Operated Provider

The following procedures will be available to providers when DMAS takes any adverse action. Adverse action, for purposes of this section, includes the termination or suspension of the provider agreement and the denial of payment for services rendered based on utilization review decisions.

The reconsideration process will consist of three phases: a written response and reconsideration to the preliminary findings, the informal conference, and the formal evidentiary hearing. The provider will have 30 days from the date of receipt of the preliminary findings to submit information for written reconsideration and will have 15 days from the date of receipt of the notice to request the informal conference and for the formal evidentiary hearing.

Written reconsideration must be filed within 30 days of the date of the final decision notification. For general school services, direct the written reconsideration to Manager, Long-Term Care Section, at the address below. For school clinic issues, direct the written reconsideration to Manager, School-Based Health Clinic Services, at the address below:

Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

If the reconsideration is denied, the provider may submit a written request for an informal meeting with DMAS staff. The request must be addressed to the appropriate Manager listed above and must be sent to the above address. If the provider is not satisfied with the results from the informal meeting, the provider may submit a written request for an evidentiary hearing. This request must be submitted to Director, Division of Quality Care Assurance, at the above address, for general school services, and to Manager, School-Based Health Clinic Services, at the above address, for clinic services.

An appeal of adverse actions concerning provider reimbursement shall be heard in accordance with the Administrative Process Act (Section 9-6.14:1 et seq.) and the State Plan for Medical Assistance provided for in Section 32.1-325 of the Code of Virginia. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the Administrative Process Act.

Any legal representative of a provider must be duly licensed to practice in the Commonwealth of Virginia.

State-Operated Provider

The following procedures will be available to state-operated providers when DMAS takes adverse action which includes termination or suspension of the provider agreement and denial of payment for services rendered based on utilization review decisions. State-operated provider means a provider of Medicaid services which is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

A state-operated provider has the right to request a reconsideration for any issue which would be otherwise administratively appealable under the State Plan by a non-state operated provider. This is the sole procedure available to state-operated providers.

The reconsideration process will consist of three phases: an informal review by the Division Director, DMAS Director review, and Secretarial review. First, the state-operated provider will submit to the appropriate DMAS Division written information specifying the nature of the dispute and the relief sought. This request must be received by DMAS within 30 calendar days after the provider receives its Notice of Amount of Program Reimbursement, notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought; the amount of the adjustment sought; and the reasons for seeking the adjustment. The Division Director or his or her designee will review this information, requesting additional information as necessary. If either party so requests, an informal meeting may be arranged to discuss a resolution.

Any designee shall then recommend to the Division Director whether relief is appropriate in accordance with applicable laws and regulations. The Division Director will consider any recommendation of his or her designee and render a decision.

A state-operated provider may, within 30 days after receiving the informal review decision of the Division Director, request that the DMAS Director or his designee review the decision of the Division Director. The DMAS Director has the authority to take whatever measures he deems appropriate to resolve the dispute.

If the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, within 30 days after receipt of the decision of the DMAS Director, the provider may request the DMAS Director to refer the matter to the Secretary of Health and Human Resources or any other Cabinet Secretary as appropriate. Any determination by such Secretary or Secretaries will be final.

MEDICAID PROGRAM INFORMATION

A provider may not wish to receive a provider manual and Medicaid Memos because he or she has access to the publications as part of a group practice. To suppress the receipt of this information, DMAS requires a statement from the provider.

To suppress the receipt of the provider manual and Medicaid Memos, complete the Program Information form (Exhibit II.7) and return it to:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-5105 or 1-888-829-5373 (in state toll-free), fax – 804-270-7027

Upon receipt of the completed form, DMAS will process it and the provider named on the form will no longer receive publications from Virginia Medicaid. To resume the mailings, a written request sent to the same address is required.

EXHIBIT II.1

PARTICIPATION AGREEMENT, DMAS-349

Medicaid Provider Number _____

Commonwealth of Virginia
Department of Medical Assistance Services
Medical Assistance Program
School Division
Participation Agreement

This is to certify that _____
Name of Provider

of _____
Street Address City & State Zip Code

on this _____ day of _____, 19_____ agrees to participate in the Virginia Medical Assistance Program (VMAP).

Provider payments and information *if different from above* should be sent to _____
Name

of _____
Street Address City & State Zip Code

1. The Provider agrees to provide only the services as licensed and certified by the Department of Education and assures that those individuals providing the services meet the criteria of this certification.
2. Services will be provided without regard to race, color, religion, or national origin. No handicapped individual shall, solely by reason of his handicap be excluded from participation in, be denied the benefits of, or be subjected to discrimination in Section 504 of the Rehabilitation Act of 1973 (29 USC § 794) VMAP.
3. The Provider agrees to keep such records as VMAP determines necessary. The provider will furnish VMAP on request information regarding payments claimed for providing services under the state plan. Access to records and facilities by authorized VMAP representatives, the Attorney General or his authorized representatives, and authorized federal personnel will be permitted under reasonable request.
4. The Provider agrees to care for patients at the current rate established by VMAP as of the date of service.
5. Payment by VMAP at its established rates for services covered constitutes full payment on behalf of the recipient except for patient pay amounts determined by VMAP, and the provider agrees not to submit additional charges to the recipient for services covered by VMAP. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a medical assistance recipient for any service provided under medical assistance is expressly prohibited and may subject the provider to federal or state prosecution.
6. The Provider agrees to pursue all other available third party payment sources prior to submitting a claim to VMAP.
7. Payment by VMAP at its established rates for the services involved shall constitute full payment for the services rendered. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by VMAP, the provider will reimburse VMAP upon demand.
8. The Provider agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of VMAP as from time to time amended.
9. This agreement may be terminated at will on thirty days' written notice by either party or by Medicaid when the applicant is no longer eligible to participate in the Medicare program.
10. All disputes regarding provider reimbursement and/or termination of this agreement by VMAP for any reason shall be resolved through administrative proceedings conducted at the office of VMAP in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.
11. The Provider agrees , at all times, to retain full responsibility for any and all performance under this agreement, whether performed by the provider or others under contract to the provider.
12. The Provider agrees to submit, no later than the 15th calendar day from the end of a calendar quarter, a certification of State/local matching funds for all Medicaid payments received during that quarter. The certification will be in the form specified by VMAP, submitted to the DMAS Fiscal Director and signed by the Superintendent of the School Division or his/her designee. Failure to submit this certification by the due date will result in the VMAP denial of Medicaid funding for provision of those Medicaid-reimbursed services and subsequent recoupment by the DMAS Fiscal Division.
13. This agreement shall commence on _____ and terminate on _____.
(To be Completed by Medicaid)

For Provider of Services by:

_____
Signature of Administrator Date

____City or ____County of_____

_____/_____
IRS Identification Number Telephone Number

For Department of Medical Assistance Services use only

by:_____
Signature Date
Director, Division of Client Services

Mail two completed original agreements to: Provider Enrollment/Certification Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

DMAS-349 R9/93

EXHIBIT II.2

PARTICIPATION AGREEMENT, DMAS-349C

Medicaid Provider Number:_____

Commonwealth of Virginia
Department of Medical Assistance Services
Medical Assistance Program
School-based Clinic

This is to certify that _____
(Name of School Division)

of _____, _____, _____-____
(Street Address) (City & State) (Zip Code)

on this _____ day of _____, 19_____, agrees to participate in the Virginia Medical Assistance Program (VMAP).

Provider payments and information *if different from above* should be sent to _____
(Name)

of _____, _____, _____-____
(Street Address) (City & State) (Zip Code)

1. The applicant has a full or part-time physician authorized to practice medicine under the laws of the state in which he is practicing and who is not as matter of state or federal law disqualified from participating in this Program, and who will direct medical services of the clinic.
2. The applicant shall be free to accept or refuse a recipient in accordance with the principles of the standards of ethics of the professional association of his area of practice. Services will be provided without regard to race, color, religion, or national origin. No handicapped individual shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in accordance with the terms of Section 504 of the Rehabilitation Act of 1973, (29 U.S.C.§ 794) in VMAP.
3. The applicant agrees to keep such records as VMAP determines necessary. The applicant will furnish VMAP on request information regarding payments claimed for providing services under the state plan. Access to records and facilities by authorized VMAP representatives, the Attorney General, or his authorized representatives, and federal personnel will be permitted upon reasonable request.
4. The applicant agrees that charges submitted for services rendered will be based on the usual, customary, and reasonable concept and agrees that all requests for payment will comply in all respects with the policies of VMAP for the submission of claims.
5. Payment made by VMAP constitutes full payment except for patient pay amounts determined by VMAP, and the applicant agrees not to submit additional charges to the recipient for services covered under VMAP.
6. The applicant agrees to pursue all other available third party payment sources prior to submitting a claim to VMAP.
7. Payment by VMAP at its established rates for the services involved shall constitute full payment to the provider. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by VMAP, the provider will reimburse VMAP upon demand.
8. The applicant agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of VMAP as from time to time amended.
9. This agreement may be terminated at will on 30 (thirty) days' written notice by either party.
10. All disputes regarding provider reimbursement and/or termination of this agreement by VMAP for any reason shall be resolved through administrative proceedings conducted at the office of VMAP in Richmond, Virginia.
11. **This agreement shall commence on _____ and terminate on _____.**
(To be completed by VMAP)

DO NOT USE
for Department of Medical Assistance Services

_____
Signature Date
Director, Division of Client Services

_____
Signature of Superintendent Date

____City or____County of_____

_____/_____
School Division IRS Identification # Telephone Number

_____
Name of Supervising Physician

_____
Signature of Supervising Physician

Mail two completed copies to: Provider Enrollment/Certification Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

DMAS349C R3/94

EXHIBIT II.3

MEDICAID PROGRAM STATE/LOCAL MATCH
QUARTERLY CERTIFICATION

TO: **Fiscal Director**
Department of Medical Assistance Services

FROM: _____
Superintendent

_____
School Division/District

SUBJECT: **Medicaid Program School Based General Services**
Quarterly Match Certification

I hereby certify on behalf of the above-named school division/district, that for the quarter ended _____, that State and local funds in the amount of $ _____ have been expended and billed for general services such as physical therapy and psychiatry services in accordance with the Inter-Agency Agreement between the Department of Education and the Department of Medical Assistance Services, and the provider agreement between the school division and DMAS.

Supporting documentation substantiating the matching expenditure of State/local funds for the provision of services to Medicaid recipients is on file and available for review and audit in school division/district offices.

Signature: _____ **Date:** _____
Superintendent

Return to: **DEPARTMENT OF MEDICAL ASSISTANCE SERVICES**
600 EAST BROAD STREET, SUITE 1300
RICHMOND, VIRGINIA 23219

ATTENTION: FISCAL DIRECTOR

10J.Garland.doc.nelson
DOE-School Based Clinic Services
May 12, 1994

EXHIBIT II.4

MEDICAID PROGRAM SCHOOL-BASED CLINIC
QUARTERLY MATCH CERTIFICATION - MEDICAL

TO: **Fiscal Director**
Department of Medical Assistance Services

FROM: _____
Superintendent

_____
School Division/District

SUBJECT: **Medicaid Program School Based Clinic Services**
Quarterly Match Certification - Medical

I hereby certify on behalf of the above-named school division/district, that for the quarter ended _____, that State and local funds in the amount of $ _____ have been expended and billed for clinic services in accordance with the Inter-Agency Agreement between the Department of Education and the Department of Medical Assistance Services, and the provider agreement between the school division and DMAS.

Supporting documentation substantiating the matching expenditure of State/local funds for the provision of services to Medicaid recipients is on file and available for review and audit in school division/district offices.

Signature: _____ **Date:** _____
Superintendent

Return to: **DEPARTMENT OF MEDICAL ASSISTANCE SERVICES**
600 EAST BROAD STREET, SUITE 1300
RICHMOND, VIRGINIA 23219

ATTENTION: FISCAL DIRECTOR

10J.Garland.doc.nelson
DOE-School Based Clinic Services
02/09/94 09:33 AM

EXHIBIT II.5

MEDICAID PROGRAM SCHOOL-BASED CLINIC QUARTERLY MATCH CERTIFICATION - ADMINISTRATION

TO: **Fiscal Director**
Department of Medical Assistance Services

FROM: _____
Superintendent

_____
School Division/District

SUBJECT: **Medicaid Program School Based Clinic Services**
Quarterly Match Certification - Administration

I hereby certify on behalf of the above-named school division/district, that for the quarter ended _____, that State and local funds in the amount of $ _____ have been expended and billed for outreach services for qualified Medicaid recipients in accordance with the Inter-Agency Agreement between the Department of Education and the Department of Medical Assistance Services, and the outreach special contract between the school division and the Department of Education. Payment for outreach services will be made within 30 days of receipt of the quarterly match certification form.

Supporting documentation substantiating the matching expenditure of State/local funds for the provision of services to Medicaid recipients is on file and available for review and audit in school division/district offices.

Signature: _____ **Date:** _____
Superintendent

Return to: **DEPARTMENT OF MEDICAL ASSISTANCE SERVICES**
600 EAST BROAD STREET, SUITE 1300
RICHMOND, VIRGINIA 23219

ATTENTION: FISCAL DIRECTOR

10J.Garland.doc.nelson
DOE-School Based Clinic Services
02/09/94 09:33 AM

EXHIBIT II.6

THIRD-PARTY LIABILITY INFORMATION REPORT
DMAS-1000

VIRGINIA

Department of Medical Assistance Services
600 East Broad Street
Suite 1300
Richmond, Virginia
23219

THIRD PARTY LIABILITY INFORMATION REPORT

(FOR MEDICAID PROVIDERS' USE)

This form MUST be submitted to the Department of Medical Assistance Services within 30 days after a service is rendered to a Virginia Medicaid recipient for the treatment of accident related injuries. Federal Regulations (42CFR - 433.138) require the Department of Medical Assistance Services to exert positive efforts toward locating liable third parties and to diligently seek refunds of applicable liability payments. Please complete this form to the best of your knowledge to assist us in this effort. Statutory authority is provided for full recovery of funds from liable third parties in Section 8.01-66.9 of the Code of Virginia.

PLEASE TYPE OR PRINT

NAME OF RECIPIENT: _____
(LAST) (FIRST) (MI)

RECIPIENT'S ELIGIBILITY NO. _____ DATE OF INJURY _____

TYPE OF ACCIDENT _____ DATE YOUR SERVICE BEGAN _____
(WORK, AUTO, HOME, GUNSHOT, ETC.)

NAME OF ATTORNEY _____

ADDRESS _____

(IF RECIPIENT HAS AN ATTORNEY, THE FOLLOWING INFORMATION IS NOT NEEDED.)

NAME OF INSURANCE COMPANY _____

ADDRESS _____

NAME OF INSURED PERSON _____

POLICY NO. _____ CLAIM NO. _____

COMMENTS _____

DIAGNOSIS _____ NAME OF PROVIDER _____

IS TREATMENT COMPLETED _____ YES _____ NO

DATE _____ BY _____

Providers will not be involved in litigation or collection attempts by the Department of Medical Assistance Services nor will reimbursement to the provider be withheld as a result of submitting this form.

PLEASE MAIL TO:

THIRD PARTY LIABILITY/CASUALTY
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
600 E. BROAD STREET, SUITE 1300
RICHMOND, VIRGINIA 23219

DMAS - 1000 R9/87

EXHIBIT II.7

MEDICAID PROGRAM INFORMATION

MEDICAID PROGRAM INFORMATION

I do not wish to receive the following publications:

___ Provider Manuals

___ Medicaid Memorandums

This information is available to me under Medicaid provider number _____.

I understand that I will be required to submit a written request for resumption of these publications if my needs change in the future.

_____
Provider Name

_____
Provider Signature **Date**

_____
Medicaid Provider Number

_____
IRS Number

Please return completed form to:

Provider Enrollment Unit
Division of Client Services
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